Safe Harbor Chiropractic, P.C.

Pediatric Case History & Intake

Child's Name: _____ Date: _____

Address: _____ Town: _____ Zip: _____

Birthdate: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Siblings: _____

Parents: _____

Contact Email for appointments and communications: _____

Cell Phone: _____ **Home/Work Phone:** _____

How did you hear about us? _____

Current Health Issue _____

_____

Is this a result of an injury? _____

Treatment and results received for this current health issue _____

_____

Is pain or discomfort present? If so is it:

_____Dull _____Achy _____Burning _____Numbness _____Tingling _____Radiating

_____Constant _____Intermittent _____Getting better _____Getting Worse

What makes it better:

_____Ice _____Heat _____Applied Pressure _____Rest _____Movement _____Other: _____

What makes it worse:

_____Bending _____Twisting _____Lifting _____Laying down _____Standing _____Sitting

_____Other:_____

Current Medications

_____

Surgeries

_____

SYMPTOMS Please check any <u>current or past problems</u> your child has on the list below:

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___Dizziness
___ADD/HD
___Backaches
___Heart Condition
___Chronic Earaches
___Diabetes
___Tuberculosis
___Hypertension
___Fever/Chills
___Frequent Colds
___Arthritis
___Headaches
___Asthma
___Allergies
___Runny Nose
___Itchy Eyes
___Rashes
___Unusual Moles
___Neuritis
___Sinus Trouble
___Cough/Wheeze
___Chest Pain
___Anemia
___Rheumatic Fever
___Hyperactivity
___Behavioral
___Poor Memory
___Pain Urinating
___Convulsions
___Paralysis
___Muscle Pain
___Fainting
___Broken Bones
___Sprain/Strain
___Hernias
___Neck Pain
___Arm/Elbow Pain
___Leg/Hip Pain
___Knee/Foot Pain
___Joint Pain
___Scoliosis
___Blood Disorders
___Other _____

PRENATAL HISTORY

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Complications during pregnancy? Y/N Please list _____

Ultrasounds during pregnancy: Y/N Number: _____

Medications during pregnancy/delivery: Y/N List: _____

Cigarette / Alcohol use during pregnancy: Y/N

Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____

Complications during delivery: Y/N List:

_____

Genetic disorders or disabilities: Y/N List: _____

Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

HEALTH HISTORY

Name of Pediatrician: _____ Date of last visit: _____

Address of Pediatrician: _____ Phone: _____

Has your child ever taken antibiotics? Y/N Condition treated: _____

Has your child ever been involved in a car accident? Y/N Date & Injuries _____

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Has your child ever fallen head first from (Changing Table, Bed, Stairs...) Y/N _____

Other traumas not described above? Y/N Type & Date: _____

Menarche: Y/N Age:_____

Is your child vaccinated? Y/N If so what vaccines?_____

SLEEP PATTERNS

What time does your child go to bed? _____PM Wake up? _____AM

Is your child a light sleeper? Yes OR No

Does your child have any of the following related to sleep?

_____Wake up during the night _____Sleep walk _____Leg cramps _____Sweats _____Wet the bed

_____Snore ____Shallow breather _____Apnea _____Insomnia _____Nightmares .

Other: _____

What position does your child sleep?

_____Stomach _____Back _____Sides _____Twisted _____Fetal position

Does your child use a cervical (neck) pillow? _____

DIGESTION PATTERNS Does your child experience any of the following?

_____Indigestion _____Cramping _____Heartburn _____GERD(reflux) _____Bloating _____Diarrhea

_____Difficulty having a bowel movement _____Constipation _____Poor Appetite

Other: _____

PHYSICAL ACTIVITY

_____Baseball/softball _____Hockey _____Basketball _____Football _____Soccer _____Gymnastics

_____Swimming _____Circus Camp _____Lacrosse _____Track _____Biking _____Weight Lifting

Other: _____ Frequency: _____

Any injuries from the above? If so, please provide details:

_____

DIETARY HABITS

What is your child's favorite food? _____

What is your child's least favorite food? _____

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How many fruits a day does your child eat? _____

How many vegetables a day does your child eat?_____

Does your child eat beef, chicken, fish, turkey, chicken or other meat? _____

Does your child eat dairy such as milk, cheese, yogurt, ice cream?_____

What snacks does your child eat? _____

How much water does your child drink daily? _____

Does your child take vitamins? If so, what? _____

EYE/BRAIN HEALTH

Does your child wear corrective lenses? _____

Does your child have any educational challenges? If so, what? _____

_____

Has your child seen any other Specialists? If so, who and for what? _____

_____

OVERALL HEALTH

How would you describe your child's energy level? _____

How would you describe your child's emotional health? _____

How would you describe your child's stress level? _____

Overall health and well-being goals for your child:

1. _____
2. _____
3. _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

I, _____being the parent or legal guardian of

_____hereby grant permission for my child to receive chiropractic care.

Signed _____Date _____

Witnessed _____